

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05277

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Penninsula General Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN <u>Road 3</u> STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Mrs. Clara</u> (First) <u>Almasi</u> (Middle) <u>Almasi</u> (Last)		4. DATE OF DEATH <u>May 31</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 17, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	11. BIRTHPLACE (State or foreign country) <u>Hungary</u>
13. FATHER'S NAME <u>Daniel Papp</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Miss Lucie Almasi Berlin Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s)

(b)

Arteriosclerotic cardiovascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II Embolism of liver

6 mos

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(d)

chronic cholecystitis

6 mos

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

5/28/51

chronic cholecystitis

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/15, 1951, to 5/31, 1951, that I last saw the deceased

alive on 5-31, 1951, and that death occurred at 10:45A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Kademahr M.D.

582 No Div St Salisbury Md 5/31/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 6-5-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mary W. Holloway

Dr. S. B. Bynum Berlin Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU W.S.S.

APR 28 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05278

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Penninsula General Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>Snook Hill</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>H.</u> (Last) <u>Audelatte</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 10 - 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Shop</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>James Audelatte Jr. Snook Hill, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocardial C-V Disease(c) CardiovascularII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5-18-, 1957, to 5/21-, 1957, that I last saw the deceasedalive on May 21-, 1957, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 24/57</u>	<u>Baptist</u>	<u>Snook Hill</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>5-23-57</u>	<u>Mary W. Holloray</u>	<u>Clay C. Dennis Snook Hill, Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

740849

RECEIVED
MAY 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05279

Reg. Dist. No. 332

The correct age
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Glen Ave.</u>				STREET ADDRESS <u>108 Glen Ave.</u> (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Henry</u>		(Middle) <u>Anthony</u>		(Last) <u>Bonnett</u>	
4. DATE OF DEATH		(Month) <u>May</u>		(Day) <u>21</u>		(Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 14, 1877</u>	9. AGE last birthday <u>73</u> yrs.	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Repair Shop.</u>		11. BIRTHPLACE (State or foreign country) <u>Sykesville Pa.</u>	
13. FATHER'S NAME <u>Fredrick Bonnett</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Priester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mrs. Mora Bonnett (Wife) 108 Glen Ave. Salisbury, Maryland.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>(a) <u>Immediate cause</u> <u>Coronary occlusion</u></p> <p>(b) <u>Antecedent cause(s)</u> <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u></p> <p>(c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p> </div> </div>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>W. R. Holloman</u>				ADDRESS <u>502 N. Division St. Salisbury, Md.</u>			
DATE SIGNED <u>5/21/51</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>May 23, 1951</u>		<u>Oriole Cemetery</u>		<u>Oriole, Maryland.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-21-51</u>		<u>Mary W. Holloman</u>		<u>Holloman & Co.</u>		<u>Salisbury, Md.</u>	
<u>Walter R. Holloman</u> <u>290817</u>							

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
APR 24 1951
BUREAU OF THE ARMY

MARYLAND STATE DEPARTMENT OF HEALTH

05280

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>North Clairmont Drive</u>		STREET ADDRESS (If rural, give location) <u>Quantico Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ida Ellen Bounds</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 24, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Edward Kenny</u>		14. MOTHER'S MAIDEN NAME <u>Maria Ellen Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr Eugene Bounds Salisbury Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cirrhosis of liver</u>		<u>6 mos</u>
Antecedent cause(s) (b) <u>581.0</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>124</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1-8-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cirrhosis of liver</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>26</u>		22. PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>26</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?
INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from 11-28, 1950, to 5/25, 1951, that I last saw the deceased alive on 5-18, 1951, and that death occurred at 8:00 P. from the causes and on the date stated above.

SIGNATURE Dr. Rademaker MD ADDRESS 502 W. H. Salisbury Rd DATE SIGNED 5/28/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	LOCATION (City, town, or county) <u>Salisbury Md</u>
DATE REC'D BY LOCAL REG. <u>5-29-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	24. FUNERAL DIRECTOR <u>The Hill & Johnson Co</u>	ADDRESS <u>Salisbury Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1 1951
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

05281

Reg. Dist. No.

322

1. PLACE OF DEATH - COUNTY <i>Wicomico</i>				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>Wicomico</i>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Mardela Springs</i>				CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mardela Springs - Rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>Sau Domingo</i>			
3. NAME OF DECEASED (Type or Print)		(First) <i>Virgie</i>		(Middle) <i>Mary</i>		(Last) <i>Cook</i>	
4. DATE OF DEATH		(Month) <i>May</i>		(Day) <i>24</i>		(Year) <i>1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>May 29, 1900</i>	
9. AGE last birthday <i>50</i> yrs.		If under 1 year		If under 24 hrs.		If under 12 mos.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Wicomico County, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>James Quinton</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Molock</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY No. <i>219-07-7041</i>				17. INFORMANT <i>Margaret Cook - Mardela Springs, Md., R.F.D.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Cerebral Hemorrhage</i> Antecedent cause(s) (b) <i>Hypertension</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						<i>1/2 hour</i> <i>several years</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <i>Oliver H. Fisher</i>				DATE SIGNED <i>May 22, 1957</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>				NAME OF CEMETERY OR CREMATORY <i>Sau Domingo Cemetery</i>			
DATE REC'D BY LOCAL REG. <i>5-26-57</i>				LOCATION (City, town, or county) (State) <i>Near Sharptown, Maryland</i>			
REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>				24. FUNERAL DIRECTOR <i>J. J. Thompson and Son, Federalburg, Md.</i>			

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>2nd</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Delmar</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Delmar</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Delmar Rural</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Bessie</u> (First) <u>Capes</u> (Middle) <u>Capes</u> (Last)		4. DATE OF DEATH Month <u>5</u> , Day <u>10</u> , Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1894</u>
9. AGE last birthday <u>57</u> yrs.		10. AGE last birthday If under 1 year Months <u>5</u> Days <u>10</u> Hours <u>19</u> Mins. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grout House Wk. Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maplesville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Williams</u>		14. MOTHER'S MAIDEN NAME <u>Grace Onley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>James Capes</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

immediate

Antecedent cause(s)

(b) Diabetes mellitus, mild5 yrs.(c) arteriosclerosisunder 10 yrs?11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept, 1950, to Death 5/10/67, that I last saw the deceasedalive on April 1, 1951, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ernest M. LammieM.D.Delmar, Del.5/10/67

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-14-51</u>	NAME OF CEMETERY OR CREMATORY <u>Maplesville Cem</u>	LOCATION (City, town, or county) <u>Salisbury Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-12-51</u>	REGISTRAR'S SIGNATURE <u>Charles W. Holliday</u>	24. FUNERAL DIRECTOR <u>Booker M. Webb</u>	ADDRESS <u>Salisbury Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1961
BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH

05283

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 337

1. PLACE OF DEATH- COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) Fruitland		CITY (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) Route # 1 - Box 50	
3. NAME OF DECEASED (Type or Print)	(First) Omar (Middle) (Last) Cornish	4. DATE OF DEATH	(Month) 5 (Day) 12 (Year) 1951
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH 9/17/1925
9. AGE last birthday 25 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Somerset County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton Anderson		14. MOTHER'S MAIDEN NAME Winnie Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Winnie Cornish			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
Sudden

Immediate cause

(a) **Broken neck**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY & OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway	(CITY OR TOWN) Fruitland	(COUNTY) Wicomico	(STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 5 12 1951 p 8	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Automobile accident		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

502 N. Division St. Salisbury, Maryland		5/14/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/16/51	NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	LOCATION (City, town, or county) (State) Revell Neck-Somerset-Md.
DATE REC'D BY LOCAL REG 5-14-51	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR William H. James Jr	ADDRESS Princess Anne, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 16 1951
BUREAU V. B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05284

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tyasken</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tyasken</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CLARA</u> (First) <u>DASHIELD</u> (Middle) <u>DASHIELD</u> (Last)		4. DATE OF DEATH <u>May 15</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 10, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>70</u> yrs. <u>1</u> Months <u>5</u> Days
11. BIRTHPLACE (State or foreign country) <u>Tyasken, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Percy Washield</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Marie Brooks - Philadelphia, Pa.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
331X Immediate cause (a) <u>Cerebral hemorrhage</u>		
Antecedent cause(s) (b) <u>83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 May, 1951, to 15 May, 1951, that I last saw the deceased alive on 15 May, 1951, and that death occurred at 2 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Tyasken Church Cemetery</u>	LOCATION (City, town, or county) <u>Tyasken</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-18-51</u>	REGISTRAR'S SIGNATURE <u>Mary M. Hollonay</u>	24. FUNERAL DIRECTOR <u>C. H. Messick</u>	ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05285

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> TOWN <u>Pittsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> TOWN <u>Pittsville</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>William</u> (Last) <u>Davis</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>12</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unknown</u>	8. DATE OF BIRTH <u>1886</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Howard Moore, Pittsville, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5
1700

Immediate cause

(a)

Fractured skull and Brain injury

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

sudden death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS

PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway

(CITY OR TOWN)

(COUNTY)

(STATE)

Rt. 353-Pittsville Wicomico Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY 5 12 1951 m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Hit by hit-and-run driver

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. H. Rademaker

Deputy Medical Examiner; Salisbury, Md.

5/12/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-12-51

Mary W. Holloway

Wm Howard Wells Pittsville, Md.

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 15 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05286

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
TOWN <u>Salisbury</u>		TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Gover Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward</u>	(First)	(Middle)	(Last)
4. DATE OF DEATH <u>May 2</u>	(Month)	(Day)	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>October 7, 1876</u>
9. AGE last birthday <u>74</u> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Gordons, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Henry Gobson</u>		14. MOTHER'S MAIDEN NAME <u>Emiline Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Arteriosclerotic Cardiovasc. disease Yes

Antecedent cause(s)

(b) Encephalomalacia Yes

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Arteriosclerosis, General Yes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Gangrene of rt. leg. ~ 1.5 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at			
INJURY	Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 3/20, 1951, to 5/2, 1951, that I last saw the deceasedalive on May 2, 1951, and that death occurred at 10:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-10-51</u>	<u>Stoneton Cemetery</u>	<u>Salisbury</u>	<u>Wicomico Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>5-9-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>James B. Ashwell</u>	ADDRESS <u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED
BUREAU V. S.
JUN 11 1920

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05287

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bivalve		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bivalve	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Gardiner	(Middle) Taylor	(Last) Dorman
4. DATE OF DEATH	(Month) May	(Day) 10	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 9, 1906
9. AGE last birthday 44 yrs.		10. BIRTHPLACE (State or foreign country) Quantico, Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert S. Dorman		14. MOTHER'S MAIDEN NAME Ettie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY No. 212-10-8214	
17. INFORMANT AND ADDRESS Claudia Messick Dorman		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Cerebral Hemorrhage**

24 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Reticulum Cell. Sarcoma Retro peritoneal**

4 mos.

(c) **Metastasis to Brain**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **1 Feb.**....., 1951....., to **10 May**....., 1951....., that I last saw the deceased alive on **10 May**....., 1951....., and that death occurred at **2:05 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 12, 1951	NAME OF CEMETERY OR CREMATORY Bivalve Church Cemetery	LOCATION (City, town, or county) Bivalve, Md.	(State)
DATE REC'D BY LOCAL REG. 5/11/51	REGISTRAR'S SIGNATURE Mary M. Holloway	24. FUNERAL DIRECTOR C. S. Messick, Bivalve, Md.		ADDRESS C. S. Messick, Bivalve, Md.	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAY 21 1958
RECEIVED A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cole Circle</u>		STREET ADDRESS (If rural, give location) <u>Cole Circle</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>—</u> (Middle) <u>Downs</u> (Last)		4. DATE OF DEATH <u>May 14</u> (Month) <u>14</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 17-1877-74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>PO Laurel Delaware</u>		12. CITIZEN OR WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Downs</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Jane Boddy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Martha A. Downs (Wife)</u>		18. MEDICAL CERTIFICATION <u>Cole Circle Salisbury Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis right

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart disease

5 years

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u>Salisbury</u>	(COUNTY) <u>Wicomico</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 1950</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>530 a.m.</u>		

22. I hereby certify that I attended the deceased from July 1950, to May 14 1951, that I last saw the deceased

alive on May 10 1951, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE R. L. Soller

(Degree or title)

ADDRESS Md. Delmar

DATE SIGNED 5-14-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 16-51</u>	NAME OF CEMETERY OR CREMATORY <u>Salisbury Md.</u>	LOCATION (City, town, or county) <u>Salisbury Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-15-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Holloway & Shiley Md.</u>	ADDRESS <u>Salisbury Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 17 1951
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05289

Reg. Dist. No.

332

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 914 Federal Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Nellie Ellis Elliott

3. (b) Social Security Number

216-07-6294

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Adina Elliott

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Apr. 30 - 1893

8. AGE:

Years

Months

Days

If less than one day

68

hrs.

min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation

Presser

11. Industry or business

Laundry

MOTHER

12. Name

William V.M. Ellis

13. Birthplace

14. Maiden name

Nancy Ellen Phillips

15. Birthplace

16. Informant

Address

Mrs. Carlton Phillips
Hebron, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

19. Funeral director

Address

5-2-37
(Date rec'd by registrar)

19

Chas. W. Holloman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

5-1

19

51

at

7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan

19

50

to

May 1

19

51

and that I last saw him alive on

May 1

19

51

Immediate cause of death

Cerebral thrombosishemiplegia

Due to

Hypertensive C.V. Disease

Due to

443X

Other conditions

93d

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William W. Gray

M. D. or other

Address

Salisbury, Md.

Date signed

5/2/51

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED TO THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05290

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>New York</u> COUNTY <u>Richmond</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (If not in place) <u>2 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Staten Island</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wm Penn Hotel</u>				STREET ADDRESS (If final give location) <u>Snug Island</u>	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Ernest</u>		<u>Nybert</u>		<u>Ellis</u>	<u>5</u> <u>5</u> <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)		8. DATE OF BIRTH <u>Feb 28, 1883</u>	9. AGE last birthday <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John J. Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Ellis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, to what service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>714-18-6802</u>		17. INFORMANT <u>Ernest Ellis</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

sudden death.

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Rademaker

Mrs Deputy Medical Examiner; Salisbury, Md. 5/5/51

23. FUNERAL, CREMATION OR BURIAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/8/51

Mary W. Hollway

The Myers & Johnson Co.

George C. Myers

583 W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Eastabella St.</u>		STREET ADDRESS (If rural, give location) <u>111 Elizabeth Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert</u> (First) <u>Griffin</u> (Middle) <u>Evans</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>March 8, 1855</u>		9. AGE last birthday <u>96</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Captain</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Garner Evans</u>		14. MOTHER'S MAIDEN NAME <u>Luby Evans</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Robert Wiethe Salisbury</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Ch. Myocarditis & Atherosclerosis</u>		<u>None</u>
Antecedent cause(s) (b) <u>Ch. Myocarditis & Atherosclerosis</u>		<u>None</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u>		
19a. DATE OF OPERATION <u>5/5/51</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>✓</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1951, to May 3, 1951, that I last saw the deceased alive on May 3, 1951, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE D. M. Mich (Degree or title) Med. ADDRESS Salisbury Md. DATE SIGNED 5/4/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	LOCATION (City, town, or county) <u>Salisbury Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>5-5-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>	24. FUNERAL DIRECTOR <u>The Hill & Johnson Co</u>	ADDRESS <u>Salisbury</u>
		<u>George C Hill II</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05292

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Robert</u>	<u>Lee</u>	<u>Fletcher</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 5-1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Lee Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Sara Ellen Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>Robert Lee Fletcher, Father, Pocomoke</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-5, 1951, to 5-10, 1951, that I last saw the deceasedalive on 5-9, 1951, and that death occurred at 8:40 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

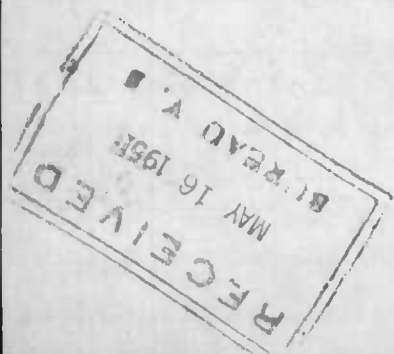
ADDRESS

205051231321

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 416



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05293

Reg. Dist. No. 382

1. PLACE OF DEATH COUNTY <u>McDonnell</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>McDonnell</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109. Brooklyn Ave</u>		STREET ADDRESS (If rural give location) <u>109. Brooklyn Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>William</u> (Last) <u>Freaney</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>9</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wt</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 25-1868</u>
9. AGE last birthday	<u>82</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
<u>Merchant</u>	<u>Freaney store</u>	<u>McDonnell Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Elyah Freaney</u>	14. MOTHER'S MAIDEN NAME <u>Ellen Fooker</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mr. Wm F. Hickey 1631 Euclid St NW</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Washington D.C.</u>	INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
Immediate cause (a) <u>Coronary Disease</u>			
Antecedent cause(s) (b) <u>Seizure</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>420.1</u> <u>94a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE <u>Thomas F. Fisher M.D.</u>	ADDRESS <u>Salisbury, Md.</u>	DATE SIGNED <u>7/11/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>May 2-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Parson Co.</u>
LOCATION (City, town, or county)	<u>Salisbury Md</u>	24. FUNERAL DIRECTOR <u>Walter R. Holloman</u>
DATE REC'D BY LOCAL REG. <u>5-12-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	ADDRESS <u>290636</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1951
BUREAU V. B.

RECEIVED
MAY 10 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05294

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Nantuxke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ROGER LYNN GAYLE</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 2, 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. If under 1 year Months <u>4</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Nantuxke, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Gayle</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Elzey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Anna Mae Gayle</u>		<u>Nantuxke Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage.

INTERVAL BETWEEN ONSET AND DEATH

1 week.

Antecedent cause(s)

(b)

Arteriosclerotic Cardiovascular Disease.1 year.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Disease.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 3, 1951, to 25 May; 1951, that I last saw the deceased alive on 25 May, 1951, and that death occurred at 8:05 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 29, 1951</u>	<u>Nantuxke M.C. Cemetery</u>	<u>Nantuxke</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-28-51</u>	<u>Mary W. Holloway</u>	<u>C. H. Messick</u>	<u>Bivalve, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

574/378

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05295

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Salisbury		CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen Hospital		STREET ADDRESS (If rural give location) 105 Cedar St.	
3. NAME OF DECEASED (Type or Print)	(First) Thomas (Middle) Cecil (Last) Gillespie, Jr.	4. DATE OF DEATH (Month) 5 (Day) 28 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Feb 16, 1946
9. AGE last birthday 5 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas C. Gillespie, Sr		14. MOTHER'S MAIDEN NAME Ella Mae Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas C. Gillespie, Sr. Pocomoke Md			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Fractured skull**

INTERVAL BETWEEN ONSET AND DEATH

4 hrs

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Compound Fracture Rt Tibia & Fibula**

4 hrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY **Street**

(CITY OR TOWN)

Pocomoke

(COUNTY)

Worcester

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **5-28-51 10 am**

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Struck by truck

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Rademacher

MD

502 No Div. Salisbury Md

5-28-51

23. BURIAL, CREMATION REMOVAL (Specify)

Buried

DATE THEREOF

6/1/51

NAME OF CEMETERY OR CREMATORY

Hall's Hill Baptist

LOCATION (City, town, or county)

Pocomoke, Md.

(State)

DATE REC'D BY LOCAL REG

5-29-51

REGISTRAR'S SIGNATURE

Charles W. Holloway

24. FUNERAL DIRECTOR

Henry H. Watson, Pocomoke, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

T

RECEIVED
JUN 1 1951
BUREAU Y. S.

05296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1332

1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
TOWN <u>Salisbury</u>		TOWN <u>Cresfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wright Nursing Home</u>		STREET ADDRESS <u>(If rural, give location)</u>	
3. NAME OF DECEASED (Type or Print) <u>William W. Green</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>7</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10/1967</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Marion Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Marion Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>William Green</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Lothie Adams</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Stroke.

Antecedent cause(s)

(b) arterio sclerosis(c) stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April, 1957, to May 7, 1957 that I last saw the deceased alive on May 7, 1957, and that death occurred at 9:08 m., from the causes and on the date stated above.

SIGNATURE <u>Carrie L. Dean MD</u>	DATE <u>5/10/57</u>	NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>	LOCATION (City, town, or county) <u>Cresfield Somerset Md.</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>	DATE REC'D BY LOCAL REG. <u>5-8-57</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Harvard Corbington</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-115

570246

RECEIVED
MAY 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crisfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Naomi</u>		(First)		(Middle)		(Last)	
4. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Education</u>		5. DATE OF BIRTH <u>Aug 24, 1884</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>66</u> yrs.		4. DATE (Month) (Day) (Year) OF DEATH <u>May 3 1957</u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leonard S. Javes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Mrs Elizabeth Watson Hall, Crisfield, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(a) Metastatic Carcinoma of Lung
(b) Carcinoma of Breast
(c) Arteriosclerotic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH
4 1/2 yrs.
3 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 9, 1957, to May 3, 1957, that I last saw the deceased

alive on May 3, 1957, and that death occurred at 7:15 a.m., from the causes and on the date stated above.

SIGNATURE David J. Gilmore M.D. (Degree or title) ADDRESS Salisbury Md. DATE SIGNED May 3, 1957

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>5-5-57</u>		NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery & Crematory</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-4-57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Covington Funeral Home</u>		ADDRESS <u>Crisfield Md.</u>	

093888

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05298

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pennington General Hospital</u>		STREET ADDRESS (If rural give location) <u>Eden</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Roland</u>	(Middle)	(Last) <u>Hargis</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5, 1911</u>
9. AGE last birthday <u>40</u> yrs.		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>13</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmer work</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Princess Anne Somerset Co</u>
13. FATHER'S NAME <u>on known</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT <u>William Hargis</u>

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

816.5 Immediate cause (a) Pulmonary Thrombosis
 Antecedent cause(s) (b) Fractured ribs - multiple
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Fractured left Radius
 1700 Fractured sternum

INTERVAL BETWEEN ONSET AND DEATH

12 hours

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY <u>Highway</u>	(CITY OR TOWN) <u>Mr. Fruitland</u>	(COUNTY) <u>Wicomico</u>	(STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 12 51/81</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>2 car collision</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

L. Rademaker M.D.

502 N. 1st St. Salisbury Md 5/14/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 20, 51</u>	NAME OF CEMETERY OR CREMATORY <u>Princess Anne</u>	LOCATION (City, town, or county) <u>Princess Anne Somerset Md</u>	(State)
DATE REC'D BY LOCAL REG <u>5-14-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Charles Howard Mason Md</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1968
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05299 332

1. PLACE OF DEATH - COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS (If rural, give location) 222 Lake St.	
3. NAME OF DECEASED (First) Joe	(Middle)	(Last) Jay	4. DATE OF DEATH (Month) 5 - (Day) 13 (Year) 1951
5. SEX Male	6. COLOR OR RACE A. A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11-15-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY E. S. Adkins & Co	9. AGE last birthday 56 yrs. If under 1 year Months 5 Days 28 If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Aiken, Aiken Co. South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Jay		14. MOTHER'S MAIDEN NAME Hester Harten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-3227	
		17. INFORMANT AND ADDRESS Mrs. Lethia Ryan, 222 Lake St. Salisbury, Md.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Cerebral Embolism Thrombosis	1 month	
Antecedent cause(s) (b) Central Nervous System Syphilis	6 months	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 29, 1951**, to **May 13, 1951**, that I last saw the deceased alive on **May 13, 1951**, and that death occurred at **4:10 P. M.**, from the causes and on the date stated above.

SIGNATURE **David J. Gilmore M.D.** ADDRESS **Salisbury Md.** DATE SIGNED **May 14, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-16-51	NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	LOCATION (City, town, or county) (State) Fruitland, Wicomico Co. Md.
DATE REC'D BY LOCAL REG. 5-15-51	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR James B. Dashiell	ADDRESS Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970000



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *332*

1. PLACE OF DEATH COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Deer's Head State</i>		STREET ADDRESS (If rural, give location) <i>1805 N. Calvert St.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Gene</i>	(Middle)	(Last) <i>Tenny</i>
4. DATE OF DEATH	(Month) <i>May</i>	(Day) <i>11</i>	(Year) <i>1957</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Aug. 4, 1918</i>
9. AGE last birthday <i>32</i> yrs.		10. UNDER 1 year	11. UNDER 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>not known</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Lake Charles, La</i>
13. FATHER'S NAME <i>Arall Tenny</i>		14. MOTHER'S MAIDEN NAME <i>May Flennigan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT, AND ADDRESS <i>Hospital Record</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

592X Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

131a

(a)

Uremia

(b)

Hypertensive cardiovascular disease

(c)

Chronic nephritis

INTERVAL BETWEEN ONSET AND DEATH

~ weeks

5 years

1 1/2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 10, 1957*, to *May 11, 1957*, that I last saw the deceased

alive on *May 11, 1957*, and that death occurred at *12:15 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-14-57

Mary W. Hollenray

Hollenray & Co. Salisbury, Md.
Walter R. Hollenray

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 16 1951
BI REAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>205 Delaware St.</u>	
3. NAME OF DECEASED (First) <u>Bell</u> (Middle) <u>Johnson</u> (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>-</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-8-1901</u>
9. AGE last birthday <u>49</u> yrs. <u>48</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Princess Anne Somerset Co. Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cannon</u>		14. MOTHER'S MAIDEN NAME <u>Lula Horsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-8739</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Robert Johnson 205 Delaware St. Salisbury, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Embolism

INTERVAL BETWEEN ONSET AND DEATH

sudden

Antecedent cause(s)

(b)

Infarct of stomach

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/19, 1951, to 5/20, 1951, that I last saw the deceasedalive on 5/19, 1951, and that death occurred at 4:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-23-51</u>	NAME OF CEMETERY OR CREMATORY <u>Wesleyan Mary Baptist Cemetery</u>	LOCATION (City, town, or county) <u>West Post Office, Somerset Co. Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-25-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>James B. Dashiell</u>	ADDRESS <u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A18

720826

RECEIVED
MAY 31 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05302 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Camden Ave.</u>		STREET ADDRESS (If rural, give location) <u>Camden Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>BEHN</u> (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>DEC. 15, 1867</u>
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT Country? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Boothe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ruark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>See Johnson, Jr.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Valvular Heart Disease</u>	<u>Unknown</u>
Antecedent cause(s) (b) <u>Viral Infection of respiratory tract</u>	<u>2 weeks</u>
(c) <u>Atherosclerosis</u>	<u>Unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 1951, to May 7, 1951, that I last saw the deceased alive on May 7, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE John R. Man (Degree or title) ADDRESS Salisbury, Md. DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	LOCALITY (City, town, or county) (State) <u>Salisbury, Md.</u>
DATE REC'D BY LOCAL REG. <u>5/8/51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>The Trust & Johnson Co.</u>	ADDRESS <u>Salisbury, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05303

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Wenona</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) (Last) <u>Johnson</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>16</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>1911</u>
9. AGE last birthday <u>40</u> yrs.		If under 1 year	If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Wenona, Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Ballard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <u>John Johnson, father</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Shock and Internal Hemorrhage</u>			<u>6 hours</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Ruptured Bladder</u>			<u>6 hrs</u>
(c) <u>Fractured pelvis</u>			<u>6 hrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>5/15/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Ruptured Bladder Intraabdominal Hemorrhage</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE OF DEATH	PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>factory plant</u>	(CITY OR TOWN) <u>Salisbury</u>	(COUNTY) <u>Wicomico</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>15</u> <u>51</u> <u>549</u> m.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>machine fell over on him</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>L. A. Rodemaker MD</u>		DATE SIGNED <u>5/16/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>5-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>Wheat Island Cemetery</u>	LOCATION (City, town, or county) (State) <u>Wheat Island, Md</u>
DATE REC'D BY LOCAL REG <u>5-16-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>LeRoy G. Webster</u>	ADDRESS <u>Wheat Island, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1961
BUREAU A. P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05304

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chance</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Road</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>EVA</u> (First) <u>MAY</u> (Middle) <u>JONES</u> (Last)		4. DATE OF DEATH <u>May 9</u> (Month) <u>9</u> (Day) <u>1951</u> (Year)	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 9, 1884</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE last birthday <u>67</u> yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James A. Kelley</u>	
14. MOTHER'S MAIDEN NAME <u>Leah Willing</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Vernon Jones - Chance, Maryland</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1950, to May 31, 1951, that I last saw the deceasedalive on May 29, 1951, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-4-51

Mary W. Holloway

Grasshawn Funeral Parlor

Crisfield, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05305

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u> Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Warwick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lee's Head State Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Graham Lockman</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>18</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-2-77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Garnett Lockman</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Stindley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Arthur J. Lockman</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Bladder tumor (Carcinoma?) 4 years

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Totally blind

18a. DATE OF OPERATION <u>July 1947</u>		19b. MAJOR FINDINGS OF OPERATION <u>Bladder tumor (Franklin Square Hosp)</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-11, 1948, to 5-18, 1957, that I last saw the deceased alive on 5-18, 1957, and that death occurred at 8:55 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

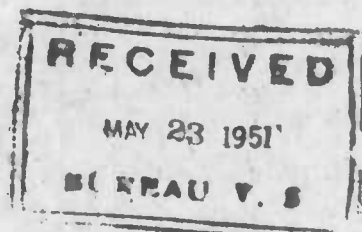
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>5/22/57</u>		<u>Warwick Cemetery</u>		<u>Warwick Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-19-57</u>		<u>Marybeth Holloway</u>		<u>The Hill & Johnson Co</u>		<u>Salisbury</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05306

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Mass.</u> COUNTY <u>Hampden</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Springfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.B. Hoyt.</u>		STREET ADDRESS (If rural, give location) <u>Wilder Schaefer</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth M. Lyons</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 24-51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 15, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, seasonal, retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. If under 1 year: Months <u>1</u> Days <u>19</u> If under 24 hrs: Hours <u>1</u> Mins. <u>19</u>
11. BIRTHPLACE (State or foreign country) <u>Mass. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Lyons</u>		14. MOTHER'S MAIDEN NAME <u>May Mitchell</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Miss Marion Hitchcock</u>		18. MEDICAL CERTIFICATION <u>15 Leigh St. Springfield</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Disease
 Antecedent cause(s) (b) 420.1
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Removal</u>	<u>May 28-51</u>	<u>St. Thomas Am. West Springfield</u>	<u>Mass.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-25-51</u>	<u>Walter W. Hollenray</u>	<u>Walter W. Hollenray</u>	<u>Salisbury, Mass.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05307

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Rd.</u>		STREET ADDRESS (If rural, give location) <u>Spring Hill Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>MAY</u> (First) <u>MARGUERITE</u> (Middle) <u>MACPHERSON</u> (Last)		4. DATE OF DEATH DATE <u>5</u> (Month) <u>3</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 14 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Coffey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jennings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C. H. Chalman</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardio-vascular Rual Disease

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1950, to May 3, 1951, that I last saw the deceasedalive on May 3, 1951, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>Rt 20 # 2</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Elsie</u> (Middle) <u>May</u> (Last) <u>McClure</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-25-1889</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wyszmar</u>		14. MOTHER'S MAIDEN NAME <u>Groth Walworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Robert S. McClure - Salisbury, Md</u>		17a. <u>Rt 20 # 2</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of Lung

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF injury bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-26, 1951, to 5-5, 1951, that I last saw the deceasedalive on May 5, 1951, and that death occurred at 12:05 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>5-7-51</u>	NAME OF CEMETERY OR CREMATORY <u>Cosby</u>	LOCATION (City, town, or county) <u>Cosby, New York</u>	(State) <u>N.Y.</u>
DATE REC'D BY LOCAL REG. <u>5/6/51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>W. S. Grand Co. - Salisbury, Md</u>		ADDRESS <u>Salisbury, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05309

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Wicomico</u> COUNTY <u>Wic</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md.</u>	
TOWN <u>Salisbury md.</u>		TOWN <u>Salisbury md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>202 Maryland Ave.</u>		STREET ADDRESS (If rural, give location) <u>202 Maryland Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Estelle</u> (First) <u>THOMAS</u> (Middle) <u>MERRILL</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 14 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Cambridge, md.</u>
13. FATHER'S NAME <u>John Henry Thomas</u>		14. MOTHER'S MAIDEN NAME <u>William</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or service)		17. INFORMANT AND ADDRESS <u>Mrs. William Phob...</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Adenocarcinoma of Pancreas</u>		<u>8 mos.</u>
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>11/13/50</u>	19b. MAJOR FINDINGS OF OPERATION <u>obstructive Common Duct</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/31, 1950, to 5/27, 1951, that I last saw the deceased alive on 5/26, 1951, and that death occurred at 4:15 a.m., from the causes and on the date stated above.

SIGNATURE William B. Long M.D. ADDRESS 504 N. Division St. Salisbury, Md. DATE SIGNED 5/28/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 29, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cambridge md.</u>
DATE REC'D BY LOCAL REG. <u>5-28-57</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>State Parkhill P. Anne, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

781826

RECEIVED

MAY 31 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05310

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rutter's Conv. Home</i>		STREET ADDRESS (If rural, give location) <i>Salisbury md</i>	
3. NAME OF DECEASED (Type or Print) <i>Alex</i> (First) <i>-</i> (Middle) <i>miles</i> (Last)		4. DATE OF DEATH (Month) <i>5</i> (Day) <i>3</i> (Year) <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>cal</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>1899</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE last birthday <i>52</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Caloentus Ga.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Madeline Rutter</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Arteriosclerotic Heart Disease 6 mo.*

Antecedent cause(s)

(b) *Arteriosclerosis*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Oct 1, 1950*, to *May 3, 1951*, that I last saw the deceasedalive on *May 3, 1951*, and that death occurred at *10 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Removal</i>	<i>5-4-51</i>	<i>Anatomical Board</i>	<i>Balto City</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>5-4-51</i>	<i>Mary W. Holloway</i>	<i>Booker West</i>	<i>Salisbury md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> LENGTH OF STAY (in this place) <u>15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westover</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>		STREET ADDRESS (If rural, give location) <u>RFD #2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wilbur</u> (Middle) <u>Clay</u> (Last) <u>Morgan</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>12</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/28/92</u>
9. AGE last birthday <u>59</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wilbur Clay Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Martha Riggin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>218-05-266</u>	
17. INFORMANT AND ADDRESS <u>Deceased on Admission</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Tuberculosis</u>			<u>6 mo.</u>
Antecedent cause(s) (b) <u>131</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY			

22. I hereby certify that I attended the deceased from 4:30-5:15, 1951, to 5:12-51, 1951, that I last saw the deceased alive on 5-12-51, 1951, and that death occurred at 5:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/14/51</u>	<u>Nelson Cemetery</u>	<u>Crisfield</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-13-51</u>	<u>Mary W. Holloway</u>	<u>Edward Covington</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

05311

564246

RECEIVED
MAY 18 1951
BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05312

Reg. Dist. No. 332

1. PLACE OF DEATH - COUNTY <u>McComick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind.</u> COUNTY <u>McComick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.O. Hspt.</u>		STREET ADDRESS <u>608. Brown St.</u>	
3. NAME OF DECEASED (First) <u>Earl</u> (Middle) <u>Franklin</u> (Last) <u>Niblett</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE - MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 23-1905</u> 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>None</u>	9. AGE last birthday <u>45</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD Salisbury</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Niblett</u>		14. MOTHER'S MAIDEN NAME <u>Ella Niblett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ella Niblett 608. Brown St. Salisbury Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Subarachnoid Hemorrhage</u>		<u>15 hrs</u>	
Antecedent cause(s) (b) <u>330X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>83a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Salisbury Md.</u>	
HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/21</u> , 19 <u>51</u> , to <u>5/22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>51</u> , and that death occurred at <u>345a</u> m., from the causes and on the date stated above.			
SIGNATURE <u>James M. D. Scholze</u>		DATE SIGNED <u>5/22/51</u>	
23. BURIAL - CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Salisbury Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-22-51</u>		24. FUNERAL DIRECTOR <u>Hollman & Scholze</u>	
REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>		ADDRESS <u>Salisbury Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05313

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.B. Hrypt.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>307. Franklin Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Hester</u> (First) <u>Osborne</u> (Middle) <u>Osborne</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 17-1908</u> - <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	11. BIRTHPLACE (State or foreign country) <u>Sky. N.C.</u>
13. FATHER'S NAME <u>William Osborne</u>		14. MOTHER'S MAIDEN NAME <u>Laura Yates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr. Locke M. Osborne (wif)</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
(a) Immediate cause <u>Hodgkins Disease</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Salisbury Md.</u>		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 50 May 18, 1957, to May 18, 1957, that I last saw the deceased alive on May 18, 1957, and that death occurred at 1235 a.m., from the causes and on the date stated above.

SIGNATURE <u>David Osborne</u>		ADDRESS <u>Salisbury Md.</u>		DATE SIGNED <u>5/18/57</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 20-57</u>		NAME OF CEMETERY OR CREMATORY <u>Salisbury Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-18-57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		24. FUNERAL DIRECTOR <u>Hillman & Hillman</u> ADDRESS <u>Salisbury Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1961
W. A. R.

MARYLAND STATE DEPARTMENT OF HEALTH

05314

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ocean City Blvd.</u>		STREET ADDRESS <u>Ocean City Blvd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ida</u> (First) <u>Foster</u> (Middle) <u>Phillips</u> (Last)	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>17</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 3, 1895</u>
9. AGE last birthday <u>56</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>David R. Foster</u>	14. MOTHER'S MAIDEN NAME <u>Mary Bayfield</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT AND ADDRESS <u>Mr. W. M. Phillips</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Adenocarcinoma of the esophagus metastatic

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

May 1950

19b. MAJOR FINDINGS OF OPERATION

Carcinoma inoperable of the esophagus closed.

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to Day of death, 1951, that I last saw the deceasedalive on 5-7-51, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)DATE REC'D BY LOCAL
REG. 5-19-51

DATE THEREOF

5/19/51

NAME OF CEMETERY OR CREMATORY

Mardela Cemetery

LOCATION (City, town, or county)

Mardela Maryland

(State)

REGISTRAR'S SIGNATURE

Harry W. Holloway

24. FUNERAL DIRECTOR

The Hill & Johnson Co

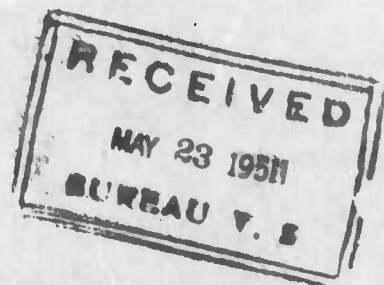
ADDRESS

SalisburyGeorge E. Hill II

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
TOWN <u>Delmar</u>		TOWN <u>Delmar</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4 West East</u>		STREET ADDRESS (If rural, give location) <u>4 West East</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ALEXANDER HENRY PINNOSKI</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 - 18 - 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-22-1896</u>
9. AGE last birthday <u>54</u> yrs.		9. AGE last birthday <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Warsaw Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Pinnoski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY No. <u>391-10-0614</u>	
17. INFORMANT AND ADDRESS <u>Albert Pinnoski - Delmar, Del.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage R.

Antecedent cause(s)

(b) Arteriosclerosis(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

8 mo

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Decubital ulcers on back & legs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1950, to May 18, 1951, that I last saw the deceased alive on May 17, 1951, and that death occurred at 12:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-21-51</u>	<u>St. Olives</u>	<u>Delmar, Del.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 18, 1951</u>	<u>Harry E. Hudson</u>	<u>M. S. Spauld Co.</u>	<u>Delmar, Del.</u>

672-588

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Riverroad</u>		TOWN <u>Quantics Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JEANETTE</u> <u>Williams</u> <u>Pokitt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>1</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 16 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alonzo L. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John E. Jack</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>4 mos</u>	
Antecedent cause(s) (b) <u>Arterio Sclerosis</u>		<u>Unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from... <u>Dec 30</u> , 19... to <u>May 1</u> , 19... that I last saw the deceased alive on... <u>April 27</u> , 19... and that death occurred at... <u>6 a</u> ... m., from the causes and on the date stated above.			
SIGNATURE <u>Henry R. Mann</u>		ADDRESS <u>Physician Salisbury Md</u>	
DATE SIGNED <u>5/2/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/3/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
24. FUNERAL DIRECTOR <u>George C Hill & Co</u>		ADDRESS <u>Salisbury</u>	
DATE REC'D BY LOCAL REG. <u>5-4-51</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05317

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Porterhaven</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Porterhaven</u>		STREET ADDRESS <u>Salisbury</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Ruth</u> (First) <u>Bushman</u> (Middle) <u>Porter</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1, 1902</u>
9. AGE last birthday <u>48</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>2</u> Hours <u>19</u> Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pharis E. Bushman</u>		14. MOTHER'S MAIDEN NAME <u>Rose Holland</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr Edgar Porter Jr.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Heart Disease

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-3-51</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1948, 1951, to 5/2, 1951, that I last saw the deceasedalive on 5/2 1951 and that death occurred at 8:45 A.m., from the causes and on the date stated above.SIGNATURE Frederic P. Gramse ADDRESS M-H Salisbury Md DATE SIGNED 5/3/51

23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	DATE THEREOF <u>5/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Wico. Mem. Park</u>	LOCATION (City, town, or county) <u>Salisbury Md.</u>
DATE REC'D BY LOCAL REG. <u>5-3-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>The Hill & Johnson Co</u>	ADDRESS <u>Salisbury</u>

George C Hill II

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05318

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Rinalto #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 E. Trabella</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (First) <u>Mollie</u> (Middle) <u>E.</u> (Last) <u>Fury</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1937</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 14, 1874</u>
9. AGE last birthday <u>77 2/3</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dumbone</u>
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>White</u>	
13. FATHER'S NAME <u>Frank Cross</u>		14. MOTHER'S MAIDEN NAME <u>Elmer White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Michael E. Fury Snow Hill, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X Immediate cause (a) Carcinoma of Breast - Metastatic

50 Antecedent cause(s) (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u></u>	(COUNTY) <u></u>	(STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at <u>Work</u> Not While <u>At work</u>	HOW DID INJURY OCCUR? <u></u>		

22. I hereby certify that I attended the deceased from 4-22, 1937, to 5-22, 1937, that I last saw the deceased alive on 5-22, 1937, and that death occurred at 11:15 P. m., from the causes and on the date stated above.

SIGNATURE <u>Frederic D. Francis</u>	DATE THEREOF <u>May 26, 1937</u>	NAME OF CEMETERY OR CREMATORY <u>Walter's Methodist</u>	LOCATION (City, town, or county) <u>Snow Hill, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>5-24-37</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Clayton D. Harris</u> ADDRESS <u>Snow Hill, Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05319

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Micomic</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Micomic</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mardela</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mardela</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD#2.</u>		STREET ADDRESS (If rural give location) <u>RD#2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Maria</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Sevell</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept. 1 - 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Samuel Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Deliah Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mr. Richard Bailey (daughter)</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
421.4 Antecedent cause(s) (b) <u>Chronic Valvular Disease</u>			
92d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 1944, to May 10, 1951, that I last saw the deceased alive on May 8, 1951, and that death occurred at 550 a.m., from the causes and on the date stated above.

SIGNATURE <u>H.S. Kuhlman M.D. S. Kuhlman</u>		ADDRESS <u>550 a.m.</u>	
DATE SIGNED <u>5/11/51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>May 12-51</u>		<u>Hoyt Farm. Cem.</u>	
LOCATION (City, town, county)		(State)	
<u>Wiltot Maryland</u>			
DATE REC'D BY LOCAL REG. <u>5-11-51</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Holloway & G. Sahitay</u>		ADDRESS <u>Md.</u>	
		<u>Walter R. Holloway 720826</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

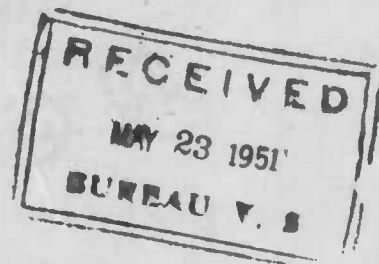
CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

05320

Reg. Dist. No. 372

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>178 W. Locust St.</u>				STREET ADDRESS <u>178 W. Locust St.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Frances</u>		(Middle) <u>Silverstein</u>		(Last)	
4. DATE OF DEATH		(Month) <u>5</u>		(Day) <u>20</u>		(Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 8, 1873</u>		9. AGE last birthday <u>78</u> yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Pa.</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel William Pescher</u>				14. MOTHER'S MAIDEN NAME <u>Marianne Silverstein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mrs. Joseph Ridel</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
972X Immediate cause (a) <u>Carbon monoxide poisoning</u>						<u>sudden death</u>	
165 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION <u>none</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 20 51 13⁰⁰ m.</u>				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				HOW DID INJURY OCCUR? <u>Turned on gas jets of stove</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Dr. Rademaker MD</u>				DATE SIGNED <u>502 No. 1st St. Salisbury Md 5/20/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>5/21/51</u>			
NAME OF CEMETERY OR CREMATORY <u>Montrose Cemetery</u>				LOCATION (City, town, or county) (State) <u>Philadelphia Pa.</u>			
DATE REC'D BY LOCAL REG. <u>5-20-51</u>				24. FUNERAL DIRECTOR <u>The Wolf & Johnson Co</u>			
REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>				ADDRESS <u>Seaside C. 7th St.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY Wicomico CITY (If outside corporate limits, write RURAL and OR give nearest town) Salisbury TOWN Salisbury HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 Catherine St.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wicomico CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury TOWN Salisbury STREET ADDRESS (If rural, give location) 104 Catherine St.	
3. NAME OF DECEASED (Type or Print) Perry Wesley Slemons		4. DATE OF DEATH (Month) 5 (Day) 22 (Year) 19 51	
5. SEX Male	6. COLOR OR RACE A. A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH about 1866
9. AGE last birthday about 85 yrs.		10. BIRTHPLACE (State or foreign country) Quantico Rd. Wicomico Co., Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Fulton Slemons, 224 Third St. Salisbury, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Renal Failure**
 Antecedent cause(s) (b) **Chronic Myocarditis**
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) **Chronic Nephritis**

INTERVAL BETWEEN ONSET AND DEATH

2 wks
3 years
3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) INJURY	PLACE (Home, farm, factory, street, OF office hldg., etc.) Salisbury Wicomico Md	(CITY OR TOWN) Salisbury	(COUNTY) Wicomico	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **May 6, 1951**, to **May 21, 1951**, that I last saw the deceased alive on **May 19, 1951**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL/CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-25-51	NAME OF CEMETERY OR CREMATORY Houston Cemetery	LOCATION (City, town, or county) Salisbury, Wicomico Co., Md.
--	-----------------------------	---	--

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-25-51 Mary W. Holloway **Jarvis B. Dashiell, Salisbury, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05322

Reg. Dist. No. 332

D. Yeaman

1. PLACE OF DEATH- COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
TOWN <i>Salisbury</i>		TOWN <i>Berlin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS (If rural, give location) <i>Flower Street</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Frank</i> (Middle) <i>Small</i> (Last) <i>Small</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>May 8 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1919</i>
9. AGE last birthday <i>32 yrs.</i>		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10h. KIND OF BUSINESS OR INDUSTRY <i>Home Poultry Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Mt. Olive Wayne Co. N. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Small</i>		14. MOTHER'S MAIDEN NAME <i>Cora Swinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No. <i>239-12-7319</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Alisha Small, Berlin, Md.</i>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>T. B. - pneumonia</i>	(?)
Antecedent cause(s) (b) <i>Hodgkins Disease</i>	(?)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *May 2*, 19*51*, to *May 8*, 19*51*, that I last saw the deceased alive on *May 8*, 19*51*, and that death occurred at *12:30 a.m.*, from the causes and on the date stated above.

SIGNATURE *John H. Yeaman MD* ADDRESS *238 Camden Ave. Salisbury Md* DATE SIGNED *5/8/51*

23. BURIAL, CREMATION REMOVAL (Specify) *Removal* DATE THEREOF *5-11-51* NAME OF CEMETERY OR CREMATORY *Mt. Olive Cemetery* LOCATION (City, town, or county) (State) *Mt. Olive Wayne Co. N. C.*

DATE REC'D BY LOCAL REG. *5-11-51* REGISTRAR'S SIGNATURE *Mary W. Holloway* FUNERAL DIRECTOR *James B. Dashiell* ADDRESS *Salisbury, Md.*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05323

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>McComick</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>McComick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>RD # 4</i>		STREET ADDRESS (If rural, give location) <i>RD # 4</i>	
3. NAME OF DECEASED (Type or Print) <i>Charles Abraham Smith</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>11</i> (Year) <i>51</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Jan. 5-1899</i>
9. AGE last birthday <i>54</i> yrs		10. AGE last birthday If under 1 year: Months <i>5</i> Days <i>11</i> Hours <i>51</i> Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Killbuck Md.</i>		12. CITIZEN OR WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Smith</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Baker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>RD # 4, Salisbury Md.</i>	
17. INFORMANT AND ADDRESS <i>Mr. Thelma Smith (Wife)</i>		18. MEDICAL CERTIFICATION <i>RD # 4, Salisbury Md.</i>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Coronary Thrombosis*

INTERVAL BETWEEN ONSET AND DEATH

5 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Arteriosclerosis**1575*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Chronic nephritis

20. AUTOPSY?

Yes ☒ No ☐

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 10 51*, 19 *56*, to *May 11 51*, 19 *56*, that I last saw the deceasedalive on *May 11 51*, 19 *56*, and that death occurred at *205a* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15/



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05324

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Clarence</u>	(Middle) <u>Parker</u>	(Last) <u>Smith</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	4. DATE OF DEATH <u>May 13 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Capt. Davis</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Garner</u>	8. DATE OF BIRTH <u>May 25/1883</u>	9. AGE last birthday <u>67</u> yrs. <u>11</u> months <u>11</u> days
13. FATHER'S NAME <u>James Parker Smith</u>	11. BIRTHPLACE (State and foreign country) <u>Snow Hill, Md</u>	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	14. MOTHER'S MAIDEN NAME <u>Mary Grace Paulsme</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary H. Smith Snow Hill, Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cirrhosis of LiverAbout 2 yrs

Antecedent cause(s)

(b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/30, 1951, to 5/13, 1951, that I last saw the deceased alive on 5/13, 1951, and that death occurred at 11:55 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. REMOVAL CREMATION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-16-51Mary W. HollowayClarence Parker Smith Snow Hill, Md

290 746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MARDELA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSP</u>		STREET ADDRESS (If rural, give location) <u>RIVERTON</u>	
3. NAME OF DECEASED (Type or Print) <u>CHAYTON ERNEST Smith</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>DEC 12, 1890</u>
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>PEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EDWARD WILLIAM Smith</u>		14. MOTHER'S MAIDEN NAME <u>EMMA CHETTA</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>MRS CLAYTON Smith</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Rocky Mountain Spotted Fever

INTERVAL BETWEEN ONSET AND DEATH

7 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 30, 1951, to May 31, 1951, that I last saw the deceasedalive on May 31, 1951, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

6-2-51Mary W. HollowayPaul J. Smith, Hagerstown, MD9700W

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 832

05326

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bloxom</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>R. F. D.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Flora</u>	(Middle)	(Last) <u>Smith</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>28</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE MARRIED WIDOWED <u>MARRIED</u> (Specify)	8. DATE OF BIRTH <u>Dec. 24, 1894</u>
9. AGE last birthday <u>56</u> yrs.	If under 1 year Months <u>8</u>	If under 24 hrs. Days <u>4</u>	Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack County, Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Benjamin Smith, Bloxom, Va.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Ch. Myocarditis1 wk

Antecedent cause(s)

(b) Myocarditis1 wk

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 25, 1957, to May 28, 1957, that I last saw the deceased alive on May 28, 1957, and that death occurred at 6:50 A.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>June 3, 1957</u>	<u>First Baptist Cemetery</u>	<u>Mappsville</u>	<u>Virginia</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-1-57</u>	<u>Mary M. Holloman</u>	<u>J. Edgar Thomas</u>	<u>Accomack, Va.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1957
BUREAU A. S.

Item 14 on:

HAM NO. G 152 MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

05327

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mardella</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Malvin</u> (Middle) <u>Eugene</u> (Last) <u>Stanley</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) <u>None</u>	8. DATE OF BIRTH <u>Apr 25 1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>19</u> yrs. If under 1 year Months <u>8</u> Days <u>18</u> If under 24 hrs. Hours <u>18</u> Min.
11. FATHER'S NAME <u>John Stanley</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Winder</u>		14. BIRTHPLACE (State or foreign country) <u>MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>JOHN STANLEY</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5-1, 1951, to 5-3, 1951, that I last saw the deceased alive on 5-2, 1951, and that death occurred at 7:55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>	LOCATION (City, town, or county) <u>Salisbury MD</u>	(State)
DATE REC'D BY LOCAL REG. <u>5-5-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Willie Smith</u>	ADDRESS <u>Salisbury MD</u>	

104261 336404

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05328

1. PLACE OF DEATH COUNTY <u>Neonics</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Neonics</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD #2</u>		STREET ADDRESS (If rural, give location) <u>RD #2</u>	
3. NAME OF DECEASED (Type or Print) <u>Elych James Stungis</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 10-1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year: Months <u>11</u> Days <u>5</u> Hours <u>51</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Ind. Pittsfield Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Edward Stungis</u>		14. MOTHER'S MAIDEN NAME <u>Julia Elizabeth Parsons</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>Walter J. Stungis RD #2</u>	
17. INFORMANT AND ADDRESS <u>Walter J. Stungis RD #2</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral thrombosis R., hemiparesis L.</u>		<u>3 days</u>	
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophic</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF injury bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>5-8</u> , 19 <u>51</u> , to <u>5-11</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>51</u> , and that death occurred at <u>6:05 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>M. Schler, M.D.</u>		ADDRESS <u>Delmar, Del.</u>	
DATE SIGNED <u>8-12-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>May 13-51</u>		NAME OF CEMETERY OR CREMATORY <u>Delmar Cem.</u>	
LOCATION (City, town, or county) (State) <u>Delmar Ind.</u>			
DATE REC'D BY LOCAL REG. <u>5-12-51</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Walter R. Holloway</u>		ADDRESS <u>Salisbury Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 18 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05329 232

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Blue Head Hospital</u>		STREET ADDRESS (If rural, give location) <u>Post Office</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas Howard</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>74</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 18, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sudler</u>		14. MOTHER'S MAIDEN NAME <u>Anne Curtis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Howard Sudler</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Prostate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis -

(c) Coronary insufficiency

INTERVAL BETWEEN ONSET AND DEATH
17 1/2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) Home PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 18, 1951, to May 23, 1951, that I last saw the deceased

alive on May 23, 1951, and that death occurred at 7:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 31 1951
BUREAU X.S.

RECEIVED
MAY 31 1951
BUREAU X.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH-
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and OR give nearest town) Salisbury LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)
Richard Starr Sutcliffe

4. DATE OF DEATH (Month) (Day) (Year)
May 2 1951

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 4-29-51 9. AGE last birthday 3 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Starr Sutcliffe 14. MOTHER'S MAIDEN NAME Mary Evelyn Donoway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY No. 17. INFORMANT AND ADDRESS Mrs Richard Sutcliffe-Parsonsburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Pulmonary atelectasisCongenital

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Prematurity

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE NO INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/19/51, 1951, to 5/1, 1951, that I last saw the deceased alive on 5/1, 1951, and that death occurred at 6:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
5-2-51 Peninsula General Hospital Salisbury, Maryland

DATE REC'D BY LOCAL REG. 5-2-51 REGISTRAR'S SIGNATURE Mary W. Holloway 24. FUNERAL DIRECTOR ADDRESS Peninsula General Hospital

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20129122 232 0

RECEIVED
MAY 7 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> STATE <u>Md</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> LENGTH OF STAY (In this place) <u>5 yr.</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>410 Lake St</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> OR TOWN <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>410 Lake St</u>											
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month)		(Day)		(Year)	
<u>Robert</u>						<u>Thomas</u>		<u>5</u>		<u>25</u>		<u>1957</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year		If under 24 hrs.			
<u>male</u>		<u>col</u>		<u>married</u>		<u>1908</u>		<u>51</u> yrs.		<u>Months</u>		<u>Days</u>		<u>Hours</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>unknown</u>				<u>none</u>				<u>Pa</u>				<u>USA</u>			
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME							
<u>unknown</u>								<u>unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)								16. SOCIAL SECURITY No.				17. INFORMANT			
												<u>Maryland State Police</u>			
18. MEDICAL CERTIFICATION															
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH														INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>															
Antecedent cause(s) (b) <u>Coronary Arteriosclerosis</u>															
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)															
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.															
19a. DATE OF OPERATION								19b. MAJOR FINDINGS OF OPERATION							
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)				(CITY OR TOWN)				(COUNTY)			
SUICIDE				INJURY											
HOMICIDE															
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED				HOW DID INJURY OCCUR?							
OF				While at				Not While							
INJURY				m. Work				At work							
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>5/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> m., from the causes and on the date stated above.															
SIGNATURE <u>Leroy P. Gramse</u>								ADDRESS <u>410 Lake St Salisbury, Md</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF				NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<u>Burial</u>				<u>6-2-57</u>				<u>Public</u>				<u>Salisbury Md</u>			
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR				ADDRESS			
<u>6-2-57</u>				<u>Mary W. Holloray</u>				<u>Edgar M. Peck</u>				<u>Salisbury Md</u>			

RECEIVED

JUN 6 1951

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05332

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Accomack</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pa.</u> COUNTY <u>Lancaster</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Caledonia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.B. Hopt.</u>		STREET ADDRESS (If rural give location) <u></u>	
NAME OF DECEASED (First) <u>Melba-Joyce</u> (Middle) <u>Tomkinson</u> (Last) <u></u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify) <u></u>	8. DATE OF BIRTH <u>July 24-1918</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>32</u> yrs. If under 1 year Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. BIRTHPLACE (State or foreign country) <u>Lancaster Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Ross C. Penninger</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Kray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>M. Fred R. Hoff</u>		<u>Lancaster Pa.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Brain injury

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden death

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>	(CITY OR TOWN) <u>near Pocomoke</u> (COUNTY) <u>accomack</u> (STATE) <u>Va</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>31</u> <u>51</u> <u>9a.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>automobile accident</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. Rademacher M.D. 502 No Div St Salisbury Md 5/31/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 4-51</u>	NAME OF CEMETERY OR CREMATORY <u>Conestoga Mem. Park</u>	LOCATION (City, town, or county) <u>Lancaster Pa.</u> (State) <u></u>
DATE REC'D BY LOCAL REG. <u>5-31-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Holloway & C. Salisbury Md.</u>	ADDRESS <u>Walter R. Holloway</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Neenah</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Neenah</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Convalescent Home</u>		STREET ADDRESS (If rural give location) <u>Salisbury St.</u>	
3. NAME OF DECEASED (First) <u>Missouri</u> (Middle) <u>Soursend</u> (Last) <u>May</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>51</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan 6-1860</u>
9. AGE last birthday <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Operative</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Baker</u>		14. MOTHER'S MAIDEN NAME <u>Louise Bryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>N. Edgar Porter (att)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Carcinoma of Bladder</u>		<u>Several</u>
(b) Antecedent cause(s) <u>Smoking</u>		<u>Months</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/24, 1951, to 5/1, 1951, that I last saw the deceased alive on 5/1, 1951, and that death occurred at 505 P. m., from the causes and on the date stated above.

SIGNATURE Clara F. Fisher ADDRESS Salisbury Ind. DATE SIGNED 5-2-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>May 3-51</u>	NAME OF CEMETERY OR CREMATORY <u>Lawson Cem.</u>	LOCATION (City, town, or county) <u>Salisbury Ind.</u>	(State)
DATE REC'D BY LOCAL REG. <u>5-3-51</u>	REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>	24. FUNERAL DIRECTOR <u>Holloway & Co.</u>	ADDRESS <u>Salisbury Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05334

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hosp.</u>		STREET ADDRESS (If rural, give location) <u>202 Third St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Alice</u>	(Middle) <u>E</u>	(Last) <u>Tyler</u>
6. SEX <u>Female</u>	7. COLOR OR RACE <u>Colored</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	9. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. James, Maryland</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Boston, Charles</u>		14. MOTHER'S MAIDEN NAME <u>Boston, Rosie - maiden name not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Doris Emma, 202 Third St.</u>	
16. SOCIAL SECURITY No.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Viral pneumoniaover 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Cardio-vascular disease

>

(c) Multiple decubitus ulcers

>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Positive S.T.S.

>

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

nonenone

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>none</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 5/16, 1957, to 5/24, 1957, that I last saw the deceased alive on 5/24, 1957, and that death occurred at 12:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-27-57</u>	<u>Green Acres Cemetery</u>	<u>Salisbury, Wicomico Co., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-25-57</u>	<u>Mary W. Holloman</u>	<u>James B. Darfield</u>	<u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

J. G. Gause

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Eden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Margaret</u> (Middle) <u>Grace</u> (Last) <u>Wessells</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>3/21/1887</u>
9. AGE last birthday <u>64</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Wicomico</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Cobb</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wessells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Correll Wessells Trumbull Va</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1951, to 3/2, 1951, that I last saw the deceased

alive on 3/2, 1951, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Porterbury Cemetery</u>	LOCATION (City, town, or county) <u>Salisbury</u>	(State) <u>Wicomico</u>
DATE REC'D BY LOCAL REG. <u>5-4-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Robert Thomas</u>	ADDRESS <u>429 Parkland Avenue Salisbury, Wic.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05336

Reg. Dist. No. 332

1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>North Carolina</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fayetteville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Salisbury, Md</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>E. Williams</u>	(First) <u>E</u> (Middle) <u>W</u> (Last) <u>Williams</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>28</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>about 1923</u>
9. AGE last birthday <u>about 28 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Camp</u>	
12. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		17. SOCIAL SECURITY NO. <u>246-24-6977</u>	
18. INFORMANT <u>P. G. Hospital Salisbury, Md.</u>		19. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Intra cerebral Hemorrhage</u>		<u>3 days</u>	
(b) <u>stab wound of Brain</u>		<u>3 days</u>	
(c) <u>Antecedent cause(s)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>5/25/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>stab wound & hemorrhage of Brain</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Primary</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Labor camp</u>	(CITY OR TOWN) <u>Willards</u>	(COUNTY) <u>Wicomico</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 25 51 12 n</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>stabbed by friend</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>J. A. Kademabur MD</u>		DATE SIGNED <u>5/28/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>5-31-51</u>	NAME OF CEMETERY OR CREMATORY <u>North End Cemetery</u>	LOCATION (City, town, or county) (State) <u>Fayetteville, N.C.</u>
DATE REC'D BY LOCAL REG. <u>5-31-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>	24. FUNERAL DIRECTOR <u>James B. Dashiell</u>	ADDRESS <u>Salisbury, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05337

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Accomac	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Painter	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Thomas	(Last) Wise
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Apr. 24, 1889
9. AGE last birthday 62 yrs.		4. DATE OF DEATH 5 12 19 51	10. DATE OF DEATH 5 12 19 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Silphren Packing Co.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Accomac, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John S. Wise		14. MOTHER'S MAIDEN NAME Maggie Ashly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. 227-24-0529	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

8255 Immediate cause (a) **Fractured skull and broken neck**
 Antecedent cause(s) (b) **170 c**
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
Sudden

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
 Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Highway	(CITY OR TOWN) Fruitland, Wicomico Co., Md.	(COUNTY) Wicomico	(STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 5 12 51 8P	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Automobile accident		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

J. A. Rademaker

(Degree or title)

ADDRESS

502 N. Division Sr.

DATE SIGNED

Deputy Medical Examiner Salisbury, Md.

5/14/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 20, 1951	NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	LOCATION (City, town, or county) Painter, Va.	(State)
DATE REC'D BY LOCAL REG. May 19, 1951	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR J. Edgar Thomas, Accomac, Va.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU V. S.